More
Frequently Asked Questions

About the Family Care Pilot Demonstrations

Maximizing Medicare in Family Care - Home Health Services

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Introduction

Maximizing Medicare is integral to the financial success of a Family Care care management organization (CMO). Why? Because accessing Medicare funds is assumed in the Department's calculation of the capitation rate for a care management organization. Therefore, the care management organization loses money when it does not access Medicare funding when it can and should do so.

When the Department sets the capitation rate for a care management organization, it assumes that dual entitlees (those individuals with access to both Medicare and Medicaid services) will continue to use Medicare at the same levels as they have in previous years.

There is also a federal requirement to use Medicare. When a person is a dual entitlee with no other insurance, there is a requirement to use Medicare as the primary (first) payor and Medicaid as the payor of last resort. In other words, Medicare is regarded as primary over Medicaid. This means that, for Medicare-covered services for dual entitlees, a CMO should ensure Medicare is being billed first, before it pays for services received by a dually-entitled enrollee.

This document is a synthesis of the Medicare Home Health workshop for CMO staff provided in the fall of 2001 by United Government Services (UGS), the Federal Medicare subcontractor. It provides answers to questions asked at that presentation by Family Care staff about the basics of Medicare home health, hospice, and the prospective payment system.

UGS liaison specialists have reviewed and approved the document. In addition, the section on State Agencies has been reviewed and approved by the Department’s Bureau of Quality Assurance (BQA).

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Part I – Medicare Basics – How to Apply and Who's on First
Outline of Basic Information

A. Medicare is a health insurance program. In general, it is designed for:

1. People age 65 or older.
2. Some people with disabilities under age 65.
3. People with End-Stage Renal Disease.

B. Medicare Part A. Medicare Part A is <u>Hospital</u> Insurance.

1. Coverage and Cost
   a. Part A covers inpatient care in hospitals, critical access hospitals, skilled nursing facilities, Hospice care, and some home health care.

   b. Cost – Most people do not have to pay for Part A because they or a spouse paid Medicare taxes while they were working.

2. Eligibility
   a To receive Medicare Part A, a person or a person's spouse has to have worked 40 qualifying quarters of time (i.e., the equivalent of 10 years).

C. Medicare Part B. Medicare Part B is <u>Medical</u> Insurance.

1. Coverage and Cost
   a. Part B covers physician services, outpatient hospital care, and some medical services that Part A does not cover. The services must qualify as medically necessary.

   b. Cost – Just like other insurance policies, people pay a monthly premium for Medicare Part B. It was $54/month in 2002. Rates can change every year. For some people, this amount may be higher if they did not choose Part B when they first became eligible at age 65.

2. Enrolling in Medicare Part B
   a. If people want Medicare Part B, it is a good idea to sign up for Part A and Part B at the same time. Part B is more expensive if you sign up after the initial enrollment period, unless the delayed enrollment is due to the member having been covered under an employer group health plan.

Part I – Medicare Basics – How to Apply and Who's on First Questions and Answers

1. At what age should a member apply for Medicare?

If a member already get benefits from Social Security or the Railroad Retirement Board, he/she is automatically entitled to Medicare Part A and Part B starting the first day of the month they turn age 65. He/she will not need to do anything to enroll. The member's card will be mailed to him/her. This will entitle the member to the same benefits under Medicare that all other eligible beneficiaries receive.

If a member is under age 65 and disabled, and has been entitled to disability benefits under Social Security or the Railroad Retirement Board for 24 months, he/she will be automatically entitled to Medicare Part A and Part B beginning the 25th month of disability benefit entitlement.

If he/she is close to age 65 and not yet getting Social Security benefits or Medicare, he/she can apply for both at the same time. He/she should apply three (3) months before turning 65. This is the beginning of the seven (7)-month Initial Enrollment Period.

If you wait until your seven (7)-month Initial Enrollment Period has expired, a person won't be able to enroll until the next General Enrollment period, which is form January 1 to March 31 each year, with coverage effective the following July 1. (Also see Question 3).

2. How does a member apply for Medicare?

If a member is not receiving Social Security, he/she should call his/her local Social Security office or call the Social Security Administration at 1-800-772-1213.

In order to enroll for Medicare through the Social Security Administration, the member or their Power of Attorney (POA) must complete the paperwork.

3. What happens if a member doesn't apply when he/she is first eligible or during the Initial Enrollment Period (within three months after he/she turns age 65)?

For Part A – Even if a member keeps working after he/she turns 65, he/she should sign up for Medicare Part A. If he/she is not getting Social Security benefits or Medicare, he/she can apply for both. He/she can also apply for Medicare only.

If a member is 65 or older, and continues to work and the employer provides health insurance coverage, that individual does not have to apply for Medicare

(Part A or B). However, to avoid penalty and to ensure that Medicare becomes effective the first month after the employment ends, workers should contact the Social Security office a month or two before terminating employment.

For Part B – If a member does not sign up when he/she is first eligible, he/she may sign up during a General Enrollment Period. This period runs from January 1 through March 31 of each year. There are also special enrollment periods that people can check on by calling their local Social Security office. The cost of Part B will go up 10% for each 12-month period that a member could have had Part B but did not sign up for it. Participation in Part B is voluntary for the member.

4. Should a member apply for Medicare at age 65 even if he/she continues to be employed?

Yes. Medicare is a health insurance program for people age 65 and older, and available even if a person continues to work.

5. What about a member who is disabled and under the age of 65? When and how does this person qualify for Medicare and how does he/she apply?

There are three things to consider here: first, work history, second, length of disability, and third, marital status.

Work history – In order to qualify for Medicare, a member has to have a work history of 40 quarters (i.e., 10 years). The work history does not have to consist of 40 continuous quarters of employment. However, you must have worked in at least five of the 10 years prior to becoming disabled, or if under age 31, worked in at least half the years since you turned 21.

Length of disability – A member must have been entitled to disability benefits under Social Security or the Railroad Retirement Board for two (2) years to qualify for Medicare and must meet the work history requirement of 40 quarters of employment. "Entitled to disability benefits" means that the person has received a disability determination from the Social Security Administration.

Marital status – If the member doesn't have a work history but the spouse does, then the member is covered by the spouse's Medicare if the member meets the other two requirements.

A disabled spouse **under 65** who does not qualify for benefits on his/her own record cannot get Medicare based on the earnings record of his/her spouse even when that spouse receives Medicare. However, any spouse turning 65 may get Medicare on his/her spouse's record if that person is receiving Social Security cash benefits or Medicare.

6. Does size of the company effect Medicare payments?

The size of the company affects whether Medicare is the primary or secondary payer.

If a member is **65 or older**; has Medicare, and is covered by a group health plan because he/she or the spouse is still working, Medicare is the secondary payer if the employer has 20 or more employees. Medicare is primary if the employer has fewer than 20 employees.

If a member is **under 65** and on Medicare because of disability, Medicare is the secondary payer if the employer plan has 100 or more employees. Medicare is primary and the employer plan is secondary if the employer plan has under 100 employees.

7. What about people who are on Medicaid and Medicare and in Family Care? Who pays first?

For services that are covered by both Medicare and Family Care, Medicare pays first when appropriate, then the Family Care CMO pays remaining costs allowable not covered by Medicare but part of Family Care covered costs.

8. What does the acronym QMB refer to?

QMB stands for "Qualified Medicare Beneficiary." Qualified Medicare Beneficiary Only recipients are a special category of Wisconsin Medicaid recipients. This is a very limited benefit. QMB pays Medicare insurance premium payments for Part B and reimbursement for Medicare coinsurance and deductibles for covered Medicare services. (Part A premiums are also paid by Wisconsin Medicaid for some QMB Only recipients.)

According to Medicaid asset-counting rules, the asset limit for all Medicare buy-ins (QMB, SLMB, and SLMB+) is $4,000 for an individual and $6,000 for a couple.

Members in the deductible phase of medically needy eligibility (i.e., while spending down) do qualify for the buy-ins until they have spent down to the medically needy limit.

To quality, QMB Only recipients must:

- Have income under 100% of the federal poverty level.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Not be receiving other Wisconsin Medicaid benefits.

9. What does the acronym SLMB refer to?

SLMB stands for "Specified Low Income Medicare Beneficiary." SLMB recipients receive payments from Medicaid for Medicare Part B premiums, but they are not qualified to receive any other Medicaid benefits.

To qualify, SLMB recipients must:

- Have income under 120% of the federal poverty level.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for other regular Wisconsin Medicaid benefits.

SLMB+ is a slightly different from SLMB. SLMB+ pays the Part B premium. To qualify, SLMB+ recipients must:

- Have income from 120-135% of the federal poverty level.
- Be entitled to, but not necessarily enrolled in, Medicare Part A.
- Have income or assets too high to qualify for other regular Wisconsin Medicaid benefits.

There is another category entitled "Additional Low Income Medicare Beneficiary." A person in this category can receive partial payment of the Part B premium. Members must have an income from 135-175% of the federal poverty level.

10. What if a person has employee insurance coverage? How does this coverage relate to Medicare and Family Care?

If the insurance is based on the member's or spouse's current employment and the employer has 20+ employees (100+ for members under 65), the employee's insurance is primary, and Medicare is secondary, i.e., the employee's insurance has the first obligation to pay.

If the employee's insurance doesn't pay, and if Medicare doesn't pay, the cost is the responsibility of the Family Care CMO, assuming the service is in the Family Care benefit package and has been authorized by the CMO.

11. What about a member with Railroad Retirement Benefits (RRB)?

A member with Railroad Retirement Benefits is automatically eligible for Medicare Part A and B once he/she turns 65. He/she doesn't need to do anything to enroll -- a Medicare card will be mailed to them about 3 months before he/she turns 65. Like other beneficiaries, if a member does not want Part B, he/she needs to follow the instructions that come with the card. If he/she chooses to enroll in

Part B the premium is usually taken out of his/her monthly Railroad Retirement payment.

There is a special "Railroad Retirement Board" that answers questions for RRB beneficiaries. Members should call their local RRB with Medicare questions. They can locate their local office by calling 1-800-808-0772. There is also information on the web at www.rrb.gov.

12. Should a member who has a spouse covered by an employee insurance coverage also apply for Medicare?

A member may want to wait to sign up for Medicare Part B if his/her spouse is still working and the member has group health coverage through his/her spouse, depending on the cost and coverage of the employee insurance. If the member does not wait in this situation, the member would have to pay the monthly Part B premium, and the benefits would be of limited value since the group plan duplicates Medicare and is usually the primary payer.

13. Is it necessary to obtain supplemental insurance (frequently referred to as Medigap) in addition to basic Medicare?

It is important to remember that Medicare is just like any other insurance policy. It has services it covers and services it doesn't cover. Therefore, if a member wants those other items covered, he/she would want a supplementary policy.

The cost of supplementary policies varies with the amount of coverage requested. For dual entitlees, the cost benefit of supplemental insurance may be minimal because the supplement only pays for the cost-sharing associated with what Medicare pays for that would be covered by Medicaid, not all the long-term care services of the Family Care benefit.

More specifics are available through the Medicap Helpline at 1-800-242-1060.

Part II – Home Health Services – What's Covered and What Isn't Covered
Outline of Basic Information

A. Coverage Criteria for Medicare Home Health Services. To have home health services paid by Medicare, the member must:

1. Be under the care of a licensed physician.
2. Require intermittent skilled care.
3. Be homebound.
4. Receive services from a certified home care agency, i.e., an agency that has met the requirements for Medicare Conditions of Participation.

B. Home Health Care Services Covered Under Medicare Part A (frequently referred to "Medicare Hospital Insurance")

The following table shows the services covered under Medicare Part A and those covered in the Family Care benefit package.

	Medicare Part A Service	Family Care Benefit Pkg	
		Yes	No
1.	Part-Time Skilled Nursing	X	
2.	Physical Therapy	X	
3.	Speech-Language Therapy	X	
4.	Occupational Therapy	X	
5.	Medical Social Services	X	
6.	Home Health Aide Services	X (PCW or supp. Home care)	
7.	Durable Medical Equipment	X	
8.	Medical Supplies	X	
9.	Hospital Stays		X
10.	Skilled Nursing Facility Care	X	
11.	Hospice Care		X
12.	Blood		X
13.	Oxygen	X*	
14.	Infusion Therapy	X*	

*Please note: Many of the questions and answers below address more precisely the definition of each service and when the service is covered.

*There are specific procedure codes and setting limitations on oxygen and infusion therapy.

Important: The home health care services are covered when the member meets **all** of the criteria for home health services described in Part A above.

Medicare Part A is usually the payment source for home health services, however Medicare Part B will also cover home health services if the member meets the criteria for the benefit.

For more specifics on the Family Care service package, refer to the long-term care benefit package in the member handbook, in the CMO contract, or in the Family Care Guide for Medicaid providers. The Family Care Guide is available on the Department's Family Care and Medicaid web page, http://www.dhfs.state.wi.us/medicaid4/familycare.htm

C. Partial List of Services Covered Under Medicare Part B (Medical Insurance)– All services must be designated as "medically necessary" and require a referral from a doctor:

	Medicare Part B Service	Family Care Benefit Pkg	
		Yes	No
1.	Certain Physician Services		X
2.	Some home health care, therapy services, durable medical equipment and supplies	X	
3.	Clinical laboratory services, e.g., blood tests, urinalysis		X
4.	Outpatient hospital services and supplies received as part of a physician's care		X
5.	Blood – pints of blood received as an outpatient or part of a Part B covered service.		X
6.	Ambulance (when other transportation services would endanger health)		X
7.	Oxygen*	X	
8.	Infusion Therapy*	X	
9.	Prosthetic devices (not provided through a home health agency service)		X

*There are specific procedure codes and setting limitations on oxygen and infusion therapy.

D. Services Not Covered by Medicare (Home Health Specific)

	Services NOT Covered by Medicare	Family Care Benefit Pkg	
		Yes	No
1.	24-hour per day care in the home	X	
2.	Drugs and Biologicals		X
3.	Meals delivered to the home	X	
4.	Homemaker Services	X	
5.	Transportation	X*	
6.	Services covered under End Stage Renal Disease Program	**	**
7.	Prosthetic Devices		X
8.	Custodial Care (i.e., help with ADLs if no "skilled care" is needed)	X	

* Except ambulance and common carrier.
**Family Care provides supportive services for people with ESRD.
Medicare pays for the core ESRD services.

II - Home Health Services – What's Covered and What Isn't Covered Questions and Answers

Number of Covered Hours

1. How many hours per week of home health covered services will Medicare pay for?

Medicare will pay for up to 28-35 hours per week of qualifying home health services. If the need for care exceeds 35 hours, and the CMO has authorized the care, the home health agency would bill the additional hours to the CMO.

2. How does a member qualify for Medicare home health services?

A person must require skilled care of some sort to quality for any Medicare home health services. Therefore, if a person only needs aide services, he/she wouldn't qualify for the aide services unless he/she also required skilled care services.

3. What would be an example of a person who qualifies for the maximum number (28-35) of hours/week of home health services?

If a member is confined to bed, has severe mobility problems, receives tube feedings, and is incontinent and prone to skin breakdown—he/she would typically qualify for 1 to 2 visits each day, up to 4 hours each visit, and 28 hours per week.

Homebound Status

4. What is the current Medicare definition of "homebound"?

Homebound means that a member is normally unable to leave home and that leaving home takes "considerable and taxing" effort. A member may still be classified as homebound and may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber, or to attend religious services. This is a more liberal definition of "homebound" than has been the case in years past. (For technical reference, see Medicare Home Health Agency Manual, Chapter II, 204.1).

5. Can a member go to an adult day care on a daily basis and still be considered homebound?

According to the new Centers for Medicare & Medicaid Services (CMS) memo of February 2001 (Program Memorandum # A-01-21), a member can still be considered homebound while attending day care on a daily basis for the purpose of participating in therapeutic, psychosocial, or medical treatment IF the day care is certified by the State. The list of certified day care programs is available by calling 608/267-1446. There is a charge for the list.

6. Is weather (like Wisconsin winters) a criterion for homebound status?

No, weather is not a determining factor. The key factor is always whether it is a considerable and taxing effort to leave the home.

7. Does a member's mental status affect their homebound status?

Yes, i.e., if a person is diagnosed with dementia or a psychiatric condition such as agoraphobia, this could make a member homebound because it makes leaving home a considerable and taxing effort.

8. What if the case manager or CMO differs with the opinion of the home health agency (HHA) on the homebound status of a member?

There may be instances in which the agency does not believe the member meets homebound status and bills Family Care, when in fact the member does meet homebound status. If this occurs, the care manager should encourage the member to request that the Home Health Agency "demand bill" Medicare for payment. (This demand bill will go to a UGS person like the workshop presenter).

The demand bill is prepared by the home health agency and submitted to Medicare who will deny or pay the claim. The demand bill requires the signature of the member. If the demand bill is denied, and the care manager still believes that the member is homebound, the case may be referred to the elderly or disability specialist to consider the possibility of an appeal.

Physician Involvement

9. What role does the physician play in order for a person to receive Medicare-covered services?

The physician must prescribe a home health plan of care that authorizes the treatments and services the member will receive from the home health agency. The physician will work with a home health care nurse to decide what kind of services are needed, what type of health care professional should give those services, and how often the services are needed. The physician must periodically review the plan of care.

Medical Necessity and Skilled Care

10. How does Medicare define "medical necessity?"

Medicare defines "medical necessity" as services or supplies that:

1. Are proper and needed for the diagnosis or treatment of the medical condition;
2. Are provided for the diagnosis, direct care, and treatment of the medical condition;

3. Meet the standards of good medical practice in the medical community of the local area; and
4. Are not mainly for the convenience of the member or the member's doctor.

Medicare determines whether services are medically necessary by reviewing information reflected in the home health plan of care, in supplementary forms, and in the member's medical records.

The Medicaid definition of "medically necessary", which is also the Family Care definition, is consistent with the Medicare definition. (Family Care also has a definition for "services necessary to achieve outcomes". Both definitions are in the definitions section of the 2002 CMO contract).

11. How does Medicare define "skilled care?"

Skilled care is defined as skilled nursing care, physical therapy, speech therapy, or occupational therapy (see additional information about occupational therapy in #15 below). Skilled nursing care is a service that, by its nature, requires the skills of a licensed nurse to be provided safely and effectively. This type of service continues to be skilled even if it is taught to the member, the member's family, or other caregivers.

If the member needs skilled nursing care and there is no one trained, able, and willing to provide the care, the services of the nurse would be reasonable and necessary to the treatment of the illness or injury.

Identification of the need for a skilled service is one of single most important things a care manager can do to maximize Medicare home health coverage.

For a more detailed definition of skilled care, please refer to the language in the Code of Federal Regulations at 42 CFR 409.33.

12. Can social work service stand alone as a skilled service?

No, social work services need to be provided in combination with a qualifying skilled service like nursing or therapy.

13. Will Medicare pay for providing insulin injections several times each day for a diabetic member?

Medicare will cover daily insulin injections if the member is either physically or mentally unable to self-administer and there is no other person able and willing to do this task. An "enhanced rate" is allowed if injections are needed more than once each day. The diabetic member must also be homebound.

For example, Medicare would cover services if a member requires injections of insulin once or more per day, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional tremors, and vision loss that causes inability to self-inject.

14. Will Medicare pay for blood?

The member is responsible for payment for the first three pints of blood. For additional pints of blood, the member has to pay 20% of the Medicare approved amount after a $100.00 deductible is met.

Therapies

15. What therapy services does a member have to need in order to qualify for a Medicare episode?

In order to quality for a Medicare episode, a member needs to have a need for physical therapy, speech therapy, or a continuing need for occupational therapy.

Occupational therapy only qualifies if its need was established while there was an additional skilled service in place. The skilled services that "qualify" occupational therapy are skilled nursing, physical therapy or speech therapy.

16. Does Medicare allow therapies during short-term nursing home stays?

Yes, Medicare allows therapies during short-term nursing home stays if they are provided by the nursing home or rehabilitation clinic, i.e., not the home health agency. However, Medicare will question the medical necessity of the services if there are too many therapy services provided and not enough supporting documentation of the need to have a therapist, as opposed to nursing staff, provide the service.

17. If a member wants sterile wound care at home, but is not homebound, can a physical therapist do the wound care under the home health benefit?

No. Since the member is not homebound, he/she would not meet the qualifications for any Medicare home health services, and the wound care would not be covered as a home health benefit.

18. Should Family Care be billed if a member needs a service the specific home health agency does not provide? For instance, if a member who is eligible for skilled care from the Medicare home health agency needs physical therapy with electrical stimulation, and the home health agency cannot provide it, must the CMO provide it?

No, the home health agency should have a contract with an outpatient facility to meet this need. Family Care should not be billed in this situation.

Medical Social Services

19. What are Medicare medical social services?

Medicare medical social services help recipients with social and emotional concerns that are or are expected to be an impediment to the effective treatment of the member's medical condition. In order to be covered, the services must relate to the medical diagnosis of the member's care needs.

Examples of medical social services are: assessment of the social and emotional factors related to the member's illness; assessment of the relationship of the member's medical/nursing requirements to the member's home situation; financial resources and availability of community resource, and appropriate action to obtain available community resources to assist in resolving the member's problem.

In Family Care, these are typical case management services provided by the CMO interdisciplinary team.

20. Who can provide covered medical social services during a Medicare episode?

In order to be covered by Medicare, medical social services must be provided by a home health agency social worker with an MSW, or a BSW under the direct supervision of an MSW.

Note: Home health agencies are not required to provide social work services either directly or under contract and therefore may not provide medical social services. If this is the case, the service costs would be covered by the Family Care CMO.

Agency Qualifications

21. How does a home health agency qualify to bill Medicare?

A home health agency must be licensed by the state and must meet the federal conditions of participation (frequently referred to as COP) for home health under Medicare. If the agency meets the state and federal criteria it is certified to participate in Medicare as a home health agency.

22. What is the difference between licensure and certification for home health agencies?

For purposes of this document, licensure pertains to state legal requirements for providing certain services on a paid basis; certification pertains to federal Medicare requirements for participating as a home health provider.

A home health agency must be licensed to provide services in the State of Wisconsin. However, a home health agency does not have to be federally certified. However, in order to bill Medicare for covered services, the home health agency must be federally certified.

State licensure and federal certification are provided through the DHFS Bureau of Quality Assurance (BQA). If a case manager wants to know the status of a home health agency in this regard, he/she may contact Karen Turnure, PRQI at turnuka@dhfs.state.wi.us or by calling 608/266-7782.

23. What qualifications must a Personal Care Agency have?

Personal care agencies receive certification from the state Medicaid program, not from Medicare. To obtain Medicaid certification, a personal care provider must be a licensed home health agency, a qualifying county department, or a qualifying independent living center (ILC).

24. How should a home health agency write orders for Home Health Aide services?

The CMS publication 11 – Home Health Agency Manual Section 204.2 gives instructions on the content, specificity, and who must sign the order and when.

Practically speaking, the order is referred to as the "plan of care." The home health nurse drafts the order or plan of care, and the physician signs it.

An order must specify the type of service to be provided, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services, i.e. HHA x 3/wk x 8 wk for bathing, grooming, dressing, assisting with PT Home Exercise Plan.

25. If the home health agency only writes orders for "PCW" rather than "home health aide," would Medicare cover?

Medicare does not recognize PCWs as a category of worker. The home health agency may write an order for "personal cares." These things would be provided by a home health aide.

Personnel Qualifications – Home Health Aide, CNA, Personal Care Worker

26. How does Medicare define "home health aide?"

Medicare defines a home health aide as a person who provides services that, according to Medicare, do not require the skills of a licensed nurse. A home health aide does not have a nursing license. Typical home health aide services include help with personal care, such as bathing, using the toilet, or dressing.

Medicare does not cover home health aide services unless the member is also receiving skilled care such as nursing care, physical therapy or speech therapy. (Occupational therapy also requires a different skilled service to be in place in order to be covered by Medicare, so the combination of OT and home health aide would not quality for Medicare coverage.) The home health aide services must be part of the home care plan for treatment of the illness or injury.

27. How does a Medicare home health aide differ from a personal care worker?

"Personal care worker" (PCW) is a term used by Wisconsin Medicaid; it is not recognized by Medicare. Medicare will not pay for the services of a Wisconsin Medicaid personal care worker. Medicare only pays for services of a home health aide as defined by Medicare, and when services provided by the aide meet all of the requirements for coverage.

Wisconsin Medicaid personal care workers have fewer training requirements than Medicare home health aides. PCWs must have 40 hours of training in order to be certified, plus 12 hours of annual inservice training in order to maintain certification. PCWs may perform tasks such as grocery shopping and accompanying the member to medical appointments. The Medicare home health aide may perform such incidental services as well, such as housecleaning, meal preparation, taking out the trash, and shopping.

28. How does a Medicare home health aide differ from a Certified Nursing Assistant (CNA)?

Medicare defines a home health aide as a person who does not have a nursing license who provides services that support any service that a nurse provides. (See answer to Question 26 above). Medicare frequently refers to home health aides as "nurse aides."

The Department of Health and Family Services maintains a Nurse Aide Directory, which lists the names of nurse aides (CNAs) who, through training, testing and experience, meet federal and/or state requirements to work in Wisconsin. All states are required to keep such a list.

CNAs must complete 75 hours of training from a state approved trainer. CNAs may receive their training in a variety of settings. Some facilities provide it if the employee is willing to sign an employment agreement in which he/she agrees to work in that facility for x amount of time. Many local colleges also offer CNA training.

After completing the training, CNAs must pass a final examination. After this, their name is entered on a Directory and they receive a card similar to a driver's license. CNAs should carry this card at all times.

CNAs are required to receive twelve (12) hours of inservice training per year to keep their certification active.

All CNAs working in a licensed nursing home, home health agency, hospital, Hospice, or intermediate care facility for the mentally retarded must be listed on the Directory. These facilities must contact the Directory when hiring an aide to verify that appropriate training, testing and nursing-related services have been completed in the last 24 months.

29. Can family members be paid caregivers of Medicare services?

No. A certified Medicare Home Health agency is expressly prohibited from providing care through an employed family member and billing Medicare for that care. Medicare defines a family member as "a legally responsible relative." A legally responsible relative is a spouse or parent of a minor child. However, there may be local agency policies or guidelines regarding other types of relatives who may be hired to provide care, including minor children.

30. Is there a percentage or time breakdown allowed for "incidentals" – tasks performed in conjunction with home health aide tasks?

No. Medicare rules state that the primary reason that the home health agency is in the home must be for hands-on cares. However, if there are "incidentals" to be done while in the home, like making the bed or wiping the counters off, that would be permissible during the Medicare visit as long as it is not the only reason for the aide to be in the home.

However, it is important to note that Medicare would review closely a case in which care for incidentals appears out of proportion to the hands-on care, i.e., if the home health aide bathed the member, then performed several incidental tasks. If such a case would be medically reviewed by UGS, the home health aide services would be looked at closely to determine if they were medically reasonable and necessary.

Part III - Medicare Hospice Services
Outline of Basic Information

A. Eligibility Criteria for Medicare Hospice Services.

1. Eligible for Part A (Hospital Insurance).
2. The member's doctor and the Hospice medical director have certified that the member is terminally ill and probably has less than six (6) months to live.
3. The member has signed a statement choosing Hospice care instead of routine Medicare covered benefits for the terminal illness.
4. The member receives care from a Medicare-approved Hospice program.

B. Services Covered.

1. Physician services.
2. Nursing care.
3. Medical equipment.
4. Medical supplies.
5. Drugs for symptom control and pain relief.
6. Short-term care in the hospital, including respite care.
7. Home health aide and homemaker services.
8. Physical and occupational therapy.
9. Speech therapy.
10. Social worker services.
11. Dietary counseling.
12. Counseling for the member and family to help with grief and loss.

C. Services Not Covered by Medicare Hospice.

1. Treatment to cure the terminal illness.
2. Care from another Hospice that was not arranged by the member's Hospice.
3. Care from another provider that is the same care received from the Hospice.

III -Medicare Hospice Services
Questions and Answers

1. What is covered under the Hospice benefit?

The Medicare Hospice benefit covers all services related to a member's terminal illness. The Medicare Hospice agency assumes the role of case management. It is also responsible for the plan of care, and for obtaining medical orders directly from the physician. The Hospice agency is responsible for providing certified

nursing assistants to assist the patient/member with all needed activities of daily living. The Hospice agency arranges for respite services, and for brief periods of continuous care to stabilize medical crises. The on-call Hospice staff provides on-call services to the member after regular work hours and on weekends. The Medicare Hospice benefit also covers any acute inpatient hospitalizations related to the member's terminal illness.

2. What is the Hospice "team"?

A Hospice team is a group of people that take care of a member. The team consists of the member's family, a doctor, a nurse, clergy or other counselors, a social worker, and trained volunteers. The team works to give comfort and relief from pain to help make the most of the last months of a member's life. The focus is on care, not cure.

3. Are Medicaid Hospice services different from Medicare Hospice services?

No, there is no difference. Medicaid Hospice covers terminal services the same way as described in the previous answer.

4. Does Family Care cover Hospice Services?

The Family Care benefit package does not cover Hospice services. However, it provides many Hospice-like services, such as case management and in-home care.

5. How are Hospice services coordinated with the Family Care benefit?

The CMO should arrange for a Memorandum of Understanding (MOU) with the Hospice agency that clearly delineates the responsibilities of each organization and its staff. The Hospice RN case manager and the CMO primary care manager should directly communicate to each other with member status updates after each visit and any changes in the member's condition. It is the responsibility of the representatives from each Hospice agency to communicate pertinent information to members of the team from other respective agencies.

It should be clarified in the MOU that any changes in the living situation of the member that have a financial impact on the CMO require the agreement of the CMO. The CMO should be the primary referral source for any financial, legal, food and housing issues beyond the scope of Hospice services. Additionally, if longer periods of respite in the member home are deemed appropriate, and these services exceed the capacity of the volunteer program of the Hospice agency, the services should be provided by the CMO.

6. When may a person go outside of Hospice for care?

If there are physical problems not relating to the terminal illness, the member may go to any Medicare provider for service. For instance, if a member falls down and breaks his/her leg, he/she may go outside of the Hospice contracted providers for care. However, if a member needs to go to the doctor for breathing problems related to the terminal illness, he/she must go through Hospice contracted providers.

7. May a member revoke the Hospice benefit, i.e. may a member go "on" and "off" Hospice?

Yes, a member may go on and off Hospice and there is no limit to the number of times he/she may do this.

A Hospice patient has the right to stop receiving Hospice care for whatever reason. When/if a person is eligible, he/she may go back to Hospice care at any time.

In order to revoke the Hospice benefit, the member must sign and date a revocation form.

8. Are short-term stays in a nursing home covered by Hospice?

Yes, Hospice pays for stays in a nursing home. However, these stays are analyzed for medical necessity and are limited to five (5) days.

9. Are there any co-pay amounts under Medicare Hospice?

There is a 5 percent co-pay required for inpatient respite care. Hospice may also charge up to $5 for each prescription for outpatient drugs or other similar products for pain relief and symptom control.

10. How are Hospice agencies (Hospices) paid for these types of services?

The Hospice receives a substantial per diem daily rate to care for members. Also, the Hospice receives an enhanced rate for hospital stays and when a member needs a lot of skilled nursing and aide service.

The member should receive a packet describing covered providers who the Hospice contracts with and who are covered under the daily rate. The member would have to use a particular hospital or ambulance under contract with the Hospice.

11. Is there any limit on what a member may receive from a Hospice agency?

A Hospice should cover all member needs relating to the terminal illness. There is no limit on the amount of services that may be provided, except for 24-hour care. For instance, if a member needs a lot of aide care or social work services, these are covered under the Hospice benefit. These services are provided in whatever setting the member calls home.

12. Is there any reason a Medicare Hospice agency can refuse medically necessary care if the member has signed on and has been accepted into the Hospice program?

A Hospice agency is only obligated to pay for palliative care. Therefore, a Hospice agency is not obligated to cover services that are "medically necessary" if the services would prolong the life of a member. All medical services covered under the Hospice benefit must be approved by the Hospice agency.

13. May a Hospice agency refuse to admit someone?

Yes. A Hospice agency may refuse a member depending on staffing limitations. However, they may not discriminate between patients on Medicare and those not on Medicare. Note that a Hospice agency may refuse medically necessary care if the care is considered other than palliative after the member has been accepted into the program. (See previous answer).

Part IV – The Home Health Episode and Prospective Payment System Questions and Answers

The Medicare Home Health Episode

1. What is a Medicare "episode of care?"

An episode of care (frequently referred to just as "an episode") is a unit of payment that Medicare uses to pay home health agencies. It covers a 60-day period of services.

The amount that a home health agency receives for each episode is adjusted for the health condition and care needs of the member. The payment is also adjusted for the geographic differences in wages for home health agencies across the country.

The adjustment for the health condition, or clinical characteristics, and service needs of the member is referred to as the case-mix adjustment.

After the amount of payment is determined, Medicare provides home health agencies with payments for each 60-day "episode" of care for each member.

2. Does an episode end with a hospital admission?

A member should not be discharged until he/she meets his/her goals. However, yes, in general, a patient may be discharged before the end of an episode. For billing purposes, however, the home health agency may only bill after the end of the 60-day episode.

3. Can an agency payment rate for a member change from episode to episode?

Yes. Payment rates are adjusted to reflect significant changes in a member's condition during each Medicare-covered episode of care. Home health agencies receive less than the full 60-day episode rate if they provide only a minimal number of visits to a member. A "low-utilization payment adjustment" (LUPA) is given for a member whose episodes consist of four or fewer visits. Therefore, depending upon the member's medical condition, an episode payment amount could change from episode to episode.

4. How is the 60-day home health episode calculated?

A home health agency is paid for a 60-day episode. The member must be under the care of the home health agency as directed by the physician. The member should be discharged by the home health agency only if the home health agency meets the treatment goals, the member moves out of the geographic area or transfers to another home health agency.

Therefore, if a member is being cared for by a home health agency, then goes into the hospital, then is in a skilled nursing facility and comes back to the home health agency within the 60 days, the agency will receive payment for the home health services that occurred during that 60-day period.

The hospital and skilled nursing facility are paid apart from the home health agency.

5. What happens if a member is in the hospital on day 60 of a Medicare episode?

If a member is in the hospital on day 60 of a Medicare episode, the home health agency must discharge the member in order to start a new episode.

6. What are some examples of a Medicare episode that are not follow-ups to a hospitalization?

The following are examples of a Medicare episode that are not follow-ups to a hospitalization:

Example 1: A member may go to the doctor with an acute problem that requires monitoring, observation, and assessment, but does not need to be admitted to the hospital.

Example 2: A member may require a Foley catheter changed monthly, or a monthly Vitamin B12 shot.

Examples 3: A member may have an acute exacerbation of multiple sclerosis that renders the member homebound.

Example 4: A member may have problems with skin integrity that requires wound care.

7. May a member's homebound status change within Medicare episodes?

Yes. A member's homebound status should be reevaluated on an ongoing basis. For example, a member may be homebound upon admission, and not be home bound six weeks later.

Home Health Supplies

8. How are home health supplies billed during a Medicare episode?

Charges for certain home health supplies are consolidated under the home health benefit, and are not billed out separately.

There is no co-insurance or deductible amount due from the member for home health supplies provided during a Medicare episode.

9. Are all supplies covered during a Medicare episode?

All supplies related to the person's condition during the episode are covered. For example, if a member needs wound care during a Medicare episode, all supplies relating to these problems are covered if the cares meet coverage criteria.

Medicare does not cover incontinence supplies. The CMO is responsible for these supplies.

The Prospective Payment System

10. What is the Prospective Payment System?

The Prospective Payment System (PPS) is a Medicare payment system that is designed to help ensure appropriate reimbursements for quality, efficient home health care. The system went into effect on October 1, 2000.

Note: The new payment system does not change what is covered under the home health benefit, only the way for which it is paid. However, the new payment system appears to be a financial disincentive to provide fewer services for people with long-term care needs when utilization data for individuals with LTC needs is analyzed.

11. How does PPS work?

PPS pays home health agencies for 60-day episodes of care. As long as a member continues to remain eligible for home health services, he/she may receive an unlimited number of medically necessary episodes of care. The payments cover skilled nursing and home health aide visits, covered therapy, medical social services and disposable medical supplies needed as part of the delivery of the home health benefit.

The PPS payment goes directly to the home health agency providing and billing for the 60-day episode.

12. Is there a difference between how PPS pays for home health services for Part A versus Part B?

There is no difference.

13. Do home health agencies receive a higher payment for members with more home health needs?

Medicare pays home health agencies at a higher rate to care for those beneficiaries with greater needs.

For each 60-day episode, the payment system uses national payment rates that range from about $1,100 to $5,900. The rate depends on the intensity of care required by the member, with adjustments to reflect area wage differences.

Agencies receive additional payments for an individual member if the costs of that care are significantly higher than the specified payment rate. These "outlier" payments allow for the unusual resource needs of these members.

14. When do home health agencies receive their money from Medicare?

As part of a streamlined approval process, Medicare pays 60 percent of the initial episode payment when the agency first accepts a new Medicare client, and the remaining 40 percent at the end of the first 60-day episode. For subsequent episodes, payments are divided equally between the start and end of the episode.

15. How are home health agencies paid for durable medical equipment?

Medicare pays home health agencies and other suppliers separately for medically necessary durable medical equipment provided under the home-health plan of care. In the Balanced Budget Act (BBA) of 1999, Congress eliminated an earlier law that required agencies to bill for this equipment even if outside suppliers provided it.

16. How does Medicare oversee the quality of care provided by home health agencies?

To ensure agencies provide adequate services to members, Medicare conducts extensive medical reviews to obtain early feedback on common errors, vulnerabilities and trends. Medicare also monitors the quality of member care using information from the comprehensive member assessments (OASIS) already used by agencies.

17. Is a prospective payment-like system applied in other settings?

Yes. Medicare has paid hospitals under a prospective payment system since 1983. Medicare began to pay nursing homes under a prospective payment system in 1998. As required by the Balanced Budget Act, CMS has implemented a prospective payment system for hospital outpatient services, and is developing such a system for rehabilitation hospitals.

Part V - Member Rights
Questions and Answers

1. In general, what are the rights of a member relative to Medicare?

A member is entitled to all the benefits listed in the sections above. He/she has a right to advance notice when his/her services are no longer covered. This notice should be done orally and in writing. He/she has the right to insist that an agency bill Medicare. During the time that Medicare is determining if services will be paid, a member may choose to have the services continue. If Medicare denies payment, however, liability for costs may fall on the member. The member could appeal this denial. (See final section for telephone numbers to call for help in this regard).

2. If a member's Medicare claim is denied (either following a demand bill or in general), what can the case manager do?

The case manager can educate the member about what Medicare does and doesn't cover, and can inform the member of the appeals process. If a member decides to appeal a denied claim, the case manager may attach supporting documentation to the member's appeal letter.

The appeal letter and any additional documentation is sent to Reconsideration and Appeals at UGS. It facilitates the appeals process if the case manager includes the member's Medicare number and the name of the home health agency providing the care.

3. In addition to Department staff, what other resources with knowledge of Family Care are available to help answer Medicare-related questions?

Elderly Benefit Specialists are available to help CMO members age 60 and over on a broad range of public and private benefits and programs, including Medicare.

A Disability Benefit Specialist is on staff at each of the Resource Centers (except at Milwaukee, which serves elderly people only) and works with individuals ages 18-59 with physical and/or developmental disabilities. Like the Elderly Benefit Specialists, a Disability Benefit Specialist provides assistance on application and eligibility issues for a broad range of public and private benefits and programs, including Medicare.

Telephone numbers for the Elderly Benefit and Disability Benefit Specialists are included at the end of this document.

4. Is there a consequence for providers who consistently deny services?

There is no direct consequence. However, UGS does trend these patterns, provides provider education services, and can forward the provider name to the Fraud and Abuse Section of CMS. (See final section for more information).

5. What happens if a home health agency refuses to provide all of the services a member needs? For instance, what if the home health agency only wants to provide skilled nursing or therapy, but does not want to provide a home health aide? Also, what happens if the home health agency can no longer staff a case?

If a home health agency does an assessment and admits a member, it must provide the cares, or it should not admit the person at all and should refer the member on to another agency. The agency should consider sub-contracting to obtain needed services.

6. What can a Family Care member and a CMO do if they believe Medicare home health hours are less than a member needs and qualifies for?

The care manager should encourage the member to ask why the home health agency believes that Medicare would not cover the additional hours. It is important to remember that Medicare pays for "hands on" personal care only when there is also a need for skilled care. If a member does not accept the reason a home health agency gives for not covering additional hours, the member has the right to ask the home health agency to demand bill Medicare.

If the home health agency does a demand bill, there is the chance that upon review of the medical record Medicare would agree with the agency and deny payment. The CMO would then cover these items if they are included in the Family Care benefit package.

If the service is "medically necessary" or "necessary to achieve outcomes" as defined in the Health and Community Supports contract, and the home health agency does not provide the service, the CMO is responsible for providing the services. If the CMO denies payment, the member could grieve the CMO's denial.

7. Can a home health agency refuse to demand bill?

No, a member has the right to request a demand bill as part of his/her rights under Medicare. The member should ask the home health agency to send the claim to Medicare so that Medicare can decide if it will pay.

8. If Medicare denies payment, who pays if the member is dually eligible for Medicare and Medicaid?

If the denied payment is for a Medicaid covered service, Medicaid pays. For Family Care members, the CMO pays after Medicare, if it is for a service in the Family Care benefit package. Note: Family Care is not obliged to pay if the cause of Medicare denial is home health agency billing error or lack of necessary information from the home health agency.

9. What should Family Care agencies do when they think that the home health agency is giving the member erroneous information about Medicare rules? For example, if a home health agency tells them that Medicare won't cover aide services if they are needed more than 4 hours/day, and then offers to make arrangements for the needed, "non-covered" services at a private pay rate.

The case manager should encourage the member to tell the home health agency that he/she wants the service demand billed to Medicare. Another option is to report the agency via the Medicare hotline (1-800-447-8477).

Part VI - Bureau of Quality Assurance (BQA) Information
Questions and Answers

1. Are home health agencies allowed to discharge members after a Medicare episode is finished, even though the member at that point in time only needs personal care services?

If the Medicare-certified home health agency does not offer Medicaid personal care, it could discharge the member after consulting with and receiving concurrence of the physician.

In Family Care, the CMO is responsible for assessing need for personal care, and for providing the personal care services. It could contract with the same agency that provided the Medicare-covered services, if that agency is also a Medicaid personal care agency. Alternatively, the CMO could contract with a different provider for the personal care, or the member could find his/her own personal care worker under the self-directed supports option.

2. What is required of a home health agency if it discharges clients because it is no longer able to meet their needs?

A home health agency must provide the care and services its clients need. If it does not have the internal capacity to do so, it should sub-contract to obtain the needed services, share the case with another agency, or transfer to case entirely to another agency.

DHFS administrative rules (HFS 133.11) state that when a member has needs which the home health agency cannot meet, the home health agency shall refer the person to other agencies, social service organizations, or governmental units which are appropriate for unmet needs of the member and which may be of assistance in meeting those needs. Referrals shall include referrals to meet the needs of members for services at times before and after the normal business hours of the home health agency. Both HFS 133 and the Code of Federal Regulations (42 CFR 484) require that the agency coordinate services with other agency personnel, the physician and others serving the member. HFS 133.09 requires that the home health agency provide the member with a notice of discharge.

3. What happens to a home health agency that denies medically necessary and reasonable home health aide services to a Medicare client?

When a member is referred to the home health agency the agency conducts an assessment of the needs of the member. Following an assessment, if the home health agency determines it cannot meet the needs of the member, the agency would contact the attending physician regarding the outcome of the assessment and its decision not to admit the member.

HFS 133 and 42 CFR 484 are silent related to "medically necessary and reasonable" in regards to home health aide services.

4. May an agency sub-contract for any needed services, i.e., Registered Nurse, Home Health Aide, Occupational Therapy, Physical Therapy, Speech Therapy?

A licensed home health agency may sub-contract for any needed service. However, persons providing registered nurse services under contract may be used in non-supervisory nursing assignments only. In other words, if a home health agency contracts with a nurse to work for them, he/she may not perform supervisory duties within the home health agency. (Refer to Wisconsin Administrative Code, HFS 133.14(6)).

If the agency is Medicare certified, one of the skilled services must be provided directly and in its entirety by employees of the HHA. The other qualifying services and any additional services may be provided either directly or under arrangement. (Refer to BQA memo DSL-BQA-01-016 and S&C-02-13).

5. What should home health agencies do if they find out about cases where a Medicaid Personal Care agency is providing skilled cares for free in order to avoid referring a "skilled case" to a home health agency? The PCW agency does this in order to continue providing personal cares to the member and bill Medicaid.

If the PCW agency is not licensed or under contract and control of a licensed home health agency, a referral to BQA would be appropriate. Direct this information to Karen Turnure, PRQI at turnuka@dhfs.state.wi.us, tel: 608-266-7782, or follow local agency policies or guidelines.

The provision of both skilled nursing and other services (home health aide/personal care) requires licensure per Wisconsin Statute, Chapter 50.49 (8). Violations of the statute are referred to and enforced by the attorney general.

6. Why can't home health agencies provide only yearly PCW supervision as appropriate, like PCW agencies are now allowed to do?

Although the Division of Health Care Financing determined that less frequent supervision would be allowed under certain situations in PCW agencies, home health agencies must continue to follow rules administered through the Bureau of Quality Assurance.

Medicare certified home health agencies must meet the requirements set forth in 42CFR 484.36 related to supervision of personal care workers, if no skilled services are being provided. This provision requires that supervision be conducted no less frequently than every 62 days. HFS 133.18 (1) allows for a supervisory visit to each member's residence as often as necessary, but at least every 60 days.

Part VII- Resources

Telephone numbers are current as of July 2002.

Medicare Resources

- Social Security Administration – 1-800-772-1213
- United Government Services (UGS)
  1-800-531-9695 Home Health Beneficiary Services
  1-887-309-4290 Home Health Provider Services
  UGS Website: http://www.ugsmedicare.com
- Medicare (General) –1-800-633-4227
- Medicare Consumer Hotline – 1-800-944-0051
- Medicare Fraud and Abuse Section – 1-800-447-8477
- Medicare E-mail - www.medicare.gov
- Medigap Helpline – 1-800-242-1060
- Railroad Retirement Board – 1-800-808-0772

Department and Advocacy Resources

Elderly Benefit Specialists by Family Care County*

- Fond du Lac County– 920/929-3110
- La Crosse County – 608/785-6140
- Milwaukee County (Legal Action of Wisconsin Senior Law) – 414/278-1222; 414/278-7722
- Portage County – 715/346-1405; 1-800/586-5055
- Richland County – 608/647-6226; 608/647-8961
- Jackson County– 715/284-4301 x 277
- Kenosha County– 262-605-6646
- Trempealeau County– 715-538-2001
- Marathon County– 715-261-6070; 1-888/486-9545

*All counties and tribes have an elderly benefit specialist.

Disability Benefit Specialists by Family Care County

- Fond du Lac County – 920/929-3466; 1-888/435-7335; 920/929-3443 (TTY)
- La Crosse County – 608/785-5700; 608/785-9787 (TTY)
- Portage County – 715/346-1405; 1-800/586-5055; 715/346-1632 (TTY)
- Richland County – 608/647-4616; 1-877/641-4616
- Jackson County- 715/284-5898; 1-877/441-0915; 715/284-8941 (TTY)
- Kenosha County- 262/605-6646; 1-800/472-8008
- Trempealeau County- 715/538-2001
- Marathon County- 715/261-6077; 1-888/486-9545; 715/261-6068 (TTY)

DHFS Family Care Staff

- Marsha Musillami - 608/266-5512; musilmm@dhfs.state.wi.us
- Ruthanne Landsness - 608/261-8883; landsrm@dhfs.state.wi.us
- Alice Mirk - 608/261-8878; mirka@dhfs.state.wi.us

DHFS Bureau of Quality Assurance (BQA)

- Licensure or Certification Questions – Karen Turnure 608/266-7782; turnuka@dhfs.state.wi.us
- Survey Questions - Juan Flores 608/261-7824; florejj@dhfs.state.wi.us

WI Coalition of Aging Groups

- (CWAG); 2850 Dairy Drive, Suite 100; Madison, WI; 53718-6751; Tel: 608/224-0606

7-1-1 Wisconsin Relay Service

- (For more information, call 1-800/305-9877)